Care Quality Commission

Rider House Limited

Rider House Care Centre

Inspection report

Stapenhill Road, Burton on Trent,
Staffordshire, DE15 9AE.
Tel: 01283 512973
Website: www.elderhomes.co.uk

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected this service on 2 September 2015. The inspection was unannounced. At our previous inspection in May 2013, the service was meeting the regulations that we checked.

Rider House Care Centre provides accommodation residential, nursing and palliative care for up to 41 older people. There were 34 people who used the service at the time of our visit.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home was in need of repair and refurbishment to ensure it met people's needs and improved their wellbeing.

Mental capacity assessments had not been undertaken for a person who was unable to make decisions and people's consent was not always gained before care interventions were delivered.

Summary of findings

People's preferences regarding meals were not always sought or considered and staff did not always support people to maintain their dignity effectively. Activities were available but these does not always meet people's hobbies or interests.

Assessments were in place that identified risks to people's health and safety and care plans directed staff on how to minimise these identified risks. However staff were not always following these to ensure people's safety was maintained.

The needs of people and the staffing levels in place had an impact on the timeliness of support people received.

The provider sought people's views but this was not done on a regular basis and feedback was only given to the registered manager if concerns were identified.

People we spoke with told us they felt safe living in the home. Staff demonstrated a good awareness of the importance of keeping people safe. They understood their responsibilities for reporting any concerns regarding potential abuse.

Plans were in place to respond to emergencies to ensure people were supported appropriately.

Staff were suitably recruited to ensure the risks to people's safety were minimised. Processes were in place to ensure people received their medicines in a safe way. The staff team received training to meet people's needs and were supported by the registered manager.

People were supported to maintain good health and accessed the services of other health professionals when they needed specialist support.

People and their relatives were involved in planning and agreeing how they were cared for and supported. People felt comfortable raising concerns which demonstrated that a transparent and open management approach was in place. People knew how to make a complaint and we saw these were investigated.

The registered manager undertook audits to identify risks and take action as needed to promote people's safety and wellbeing.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Some areas of the home were in need of repair and refurbishment to ensure it met people's needs and enhanced their wellbeing. Risks to people were identified and care records described the actions required to minimise risks but staff did not always follow this guidance. The staffing levels in place did not always meet people's care needs in a timely way. Staff understood their responsibilities to keep people safe from harm. Staff were confident any concerns they raised would be listened to and appropriate action taken by the registered manager. The recruitment practices in place checked staff's suitability to work with people and medicines were managed safely.

Requires improvement

Is the service effective?
The service was not consistently effective.

People's ability to consent to care was not always identified to ensure the Mental Capacity Act 2005 was followed. Staff did not always obtain people's consent before they delivered care. Staff did not always follow guidance to ensure people's dietary needs were met. People were supported to maintain good health and access healthcare services when needed. Staff were supported in their role by the training provided and support of the registered manager.

Requires improvement

Is the service caring?
The service was not consistently caring.

People liked the staff but consideration was not always given to the timeliness of the support people received, such as waiting for their lunch time meal. People's choice in meals was not always considered. Staff were not always vigilant in ensuring people were supported to maintain their dignity. People's visitors told us they were involved in discussions about how their relatives were cared for and supported.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People's care plans were regularly reviewed and updated when changes in their individual needs or abilities were identified. Staff supported people to maintain outside interests but activities inside the home were not individualised to meet people's interests. Complaints were responded to appropriately. The provider's complaints policy and procedure were accessible to people who lived at the home and their relatives.

Requires improvement

Summary of findings

Is the service well-led? The service was not consistently well-led. People were encouraged to share their opinions about the quality of the service but this was not done consistently. The provider did not share the overall results with the registered manager. People told us the registered manager was approachable and managed the home in an open and transparent way. There were quality assurance checks in place to monitor and improve the service. The manager had fed back areas for improvement to the provider but was unsure when action was being taken to address these improvements.	**Requires improvement**

Care Quality Commission

Rider House Care Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 2 September 2015 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not send the provider a Provider Information Return (PIR) request prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. We looked at information received from the public, from the local authority commissioners and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with 20 people who lived at the home, nine people's visitors and a visiting professional. We also spoke with two volunteers, three care staff, one nurse, the cook and the registered manager.

We observed how staff interacted with people who used the service and looked at four people's care records to check that the care they received matched the information in their records.

We observed the lunch time meal to check that people were provided with food that met their needs and preferences.

We looked at the medicines and records for six people and observed the lunch time medicines administered, to check that people were given their medicines as prescribed and in a safe way.

We looked at other records that related to the care people received. This included the training records for the staff employed, to check that the staff were provided with training to meet people's needs safely.

We looked at evidence of staff supervision to see if staff were provided with support in their jobs. We looked at the recruitment records of three staff to check that the staff employed were safe to work with people.

We looked at the systems the provider had in place to monitor the quality of the service, this included satisfaction questionnaires, audits and the maintenance and servicing of equipment.

Requires improvement

Is the service safe?

Our findings

We saw that the care provided did not always reflect the information in people's risk assessments For example, a risk assessment for one person said they needed a stand aid and two care staff to support them to move. A stand aid is a piece of equipment used to support people into a standing position. We observed three separate occasions when this person was supported to move by one member of staff and no stand aid was used. This meant this person was not moved safely in accordance with their assessment.

We saw that a person had been assessed as requiring a soft diet. We saw that this person was given a piece of gammon with chips and peas for their lunch. This placed the person at risk of choking as their care plan stated they had difficulty swallowing. This demonstrated that staff were not following guidance in risk assessments to maintain people's safety and wellbeing.

In the care files seen some people used bedrails when in bed to protect them. However one person did not have a bedrail assessment in place to demonstrate that any risks associated with the use of bedrails had been identified. This meant we could not be confident that actions were in place to reduce these risks.

This is a breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

The premises and equipment had not been maintained to a good standard. We saw several areas in need of repair and refurbishment. Prior to our visit the lift had broken down on two separate occasions. The last occasion meant that the lift had been out of use for over two weeks. People whose bedrooms were on the first floor were unable to access the ground floor during this period. We received information from the local authority regarding complaints from relatives who could not visit as they were unable to walk up the stairs. The registered manager told us the delay in repairs was due to finding a company to make the parts required. This was due to the age of the lift as these parts could no longer be purchased directly. We saw that electrical equipment, such as hoists were tested and serviced, to ensure they were safe for use.

The registered manager told us that staffing levels were determined by people's needs and advised us that the needs of people receiving nursing care were high.

Comments from people and our observations demonstrated that this had an impact on the timeliness of support people received. People told us that there were occasions when they had to wait for staff support. One person said, "They've been telling me for a long time that they're coming but they don't." Another person said, "We often have to wait." Another person said, "I will have to wait half an hour for the toilet again." We observed that people's needs were not always met promptly. Call bells were not accessible to the majority of people within communal areas, which made seeking staff assistance difficult. For example one person was seen calling out and banging on a table to get staff's attention for ten minutes before staff assistance was sought.

Staff we spoke to told us there were enough staff but confirmed that during busy periods people had to wait for support. One member of staff said, "Mornings are busy because everyone wants to get up at the same time." Another member of staff told us, "In the afternoons we can spend more time with residents, playing dominoes or doing their nails." We saw that the several volunteers supported the staff by spending time sitting with people and supporting people with their meals. Although this was a credit to the home it demonstrated that the home was reliant on the support of volunteers. In the dining room at lunch time people were supported by volunteers as care staff were busy supporting people who took lunch in their rooms.

People confirmed that they were comfortable with the staff team and felt safe. One person said, "I am safe here." Another person said, "I feel safe the staff check on me." Other people told us they had not experienced anything that caused them concern.

Staff confirmed they attended safeguarding training and learnt about the whistleblowing policy during their induction. This is a policy to protect staff if they have information of concern. One member of staff told us, "If I had a problem I would go to the manager or the nurses. The whistleblowing is pinned up in staff room." Staff we spoke with knew and understood their responsibilities to keep people safe and protect them from harm. They were aware of the signs to look out for that might mean a person was at risk.

We saw that plans were in place to respond to emergencies, such as personal emergency evacuation plans. These plans provided information about the level of

Is the service safe?

support a person would need to be evacuated from the home in an emergency. The information recorded was specific to each person's individual needs and was sufficiently detailed to ensure staff knew how to evacuate people safely. Staff we spoke with were aware of the emergency evacuation plans and the support people needed.

The manager checked staff's suitability to deliver care before they started work. We looked at the recruitment checks in place for four staff. We saw that they had Disclosure and Barring Service (DBS) checks in place. The DBS is a national agency that keeps records of criminal convictions. The four staff files seen had references and disclosure and barring checks in place before they commenced their employment at the service.

We saw that medicines were kept securely in a locked cupboard to ensure they were not accessible to unauthorised people. We looked at the medicine administration records for people and saw that nurses had signed to say medicines were administered in accordance with people's prescriptions.

People told us that they received their medicines on time. We observed nursing staff administer medication and saw that they did it in a safe way. There were clear protocols for 'as required' medicines (PRN). The protocols gave clear information on the signs and symptoms someone might show when they required the medicine. We saw that people were offered their (PRN) medicines and if they refused this was respected.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where appropriate decisions are made in people's best interests when they are unable to do this for themselves. We found staff understood the requirements of the MCA and confirmed that training had been provided to them. The registered manager told us that capacity assessments had not been undertaken as no one lacked capacity to make their own decisions. However discussions with staff confirmed that one person was not able to make some decisions independently. The registered manager acknowledged that they had not recognised the need for a capacity assessment to be undertaken for this person. This meant that decisions were being made on this person's behalf without following the correct legal guidance, to ensure their rights were protected.

People's care plans were not always signed to demonstrate they had consented to their care and the measures in place to support them. For example one person who had bedrails in place had not signed to demonstrate their agreement to the use of bedrails. However this person was able to verbally confirm that they consented to bedrails being in place. We saw that staff generally gained people's verbal consent before supporting them with care. However we observed staff in preparation for lunch, putting protective clothing over people's heads whilst they were sleeping. This demonstrated that people's consent was not always sought beforehand.

The MCA and DoLS require providers to submit applications to a Supervisory Body for authority to deprive a person of their liberty. The registered manager confirmed that no DoLS authorisations were in place or needed, as none of the people that used the service were deprived of their liberty.

We spoke with the cook who confirmed that they had information in the kitchen regarding people's preferences and dietary requirements. In general we saw that people's dietary needs were met and that specific diets were followed when needed. One person's visitor told us that their relative needed a special diet. They told us, "The chef is very careful to ensure that their food is prepared with special ingredients." The care plans we looked at included an assessment of the person's nutritional requirements and their preferences.

We saw that people's health care needs were monitored and met as referrals were made to the appropriate health care professionals when needed. For example we saw that a referral to a specialist was made when a person demonstrated difficulty with swallowing. People's nutritional needs were monitored along with their weights to ensure any weight loss was detected and action taken to address this.

The staff provided palliative care to several people living at the home. Palliative care is specialised medical care for people with serious illnesses. We spoke with a visiting professional who told us they had every confidence in the staff's competence in supporting people. They said the staff had a good knowledge of palliative care and informed them of any changes. People's visitors confirmed they were informed of any illness or change in health. One visitor said, "We are always kept informed, if there are any problems they let us know."

People and their relatives told us that the staff team looked after them well and comments ranged from 'efficient', to 'attentive', 'well-trained' and 'organised.' Staff told us they received ongoing training but felt that the delivery of this training could be improved. One member of staff said, "Training could be improved, I have completed loads of booklets but there is not enough face to face training." Other comments from staff about the training included, "Most training is online which is sometimes confusing because it doesn't tell you if you have got the answer right." And "I have done online training at home, but I miss coming together to do training."

Staff told us they were supported to fulfil their role and confirmed they received regular supervision. One staff member said, "I have supervision with nurses every couple of months." Another member of staff said, "I get supervision from the nurses but the manager is approachable and I can go to her with anything." We saw that staff supported people in a safe way when helping them to mobilise and transfer using equipment. This demonstrated that staff had the competency and knowledge required to use equipment safely.

Requires improvement

Is the service caring?

Our findings

We observed the lunch time meal in the main dining area. We saw that although people were seated in the main dining area on the ground floor, meals were firstly served to people taking lunch in their rooms. The time taken from people being seated in the main dining area to receiving their meal took 40 minutes. This meant that people taking lunch in the dining area had a considerable wait for their meal.

We saw that people's preferences in meals were not always met. One person required a soft diet and told us that the options available to them were not enjoyed. The registered manager told us and we saw in their care plan that this person had agreed to try the soft diet. We discussed this with the registered manager who agreed that this person's meal options needed to be reviewed, to ensure their preferences were met.

The majority of people told us that they enjoyed the meals provided but several people said they were unaware of the meal options available. One person told us, "I don't see any menu. I don't know what there is unless I ask." Another person said, "They don't tell us." Another person said they weren't asked 'very often' about their preference. We saw that options were available and these were written on a board in the dining area. We did not see any fresh fruit on offer for people to eat. The cook told us that fresh fruit was available in the kitchen for people and said, "We have fresh fruit if people request it." However people we spoke with were not aware this was available.

People told us the staff respected their dignity and privacy and the majority of observations confirmed this. However we did observe one occasion when a person being supported to move was not covered, as their underwear was on display to other people. This demonstrated that staff were not always vigilant in ensuring people were supported to maintain their dignity.

People told us that they liked the staff and described them as 'caring', 'very nice' and 'lovely'. One person said, "The staff are excellent. You can't get better looked after. The staff are always cheerful and can't do enough for you." Another person told us the staff made Rider House, "homely and relaxed." We saw that staff were attentive to people's needs. For example, one person was trying to wipe their face after their meal. A member of staff said to the person, "Do you want me to help you with that." They gently took the tissue from this person's hand and wiped their face. We saw that staff were polite and kind to people but most interactions were task orientated. One person said, "Staff are good, they come in and chat if they have time". We saw that volunteers were present during the morning. They told us their relative had lived at the home and spoke positively about the care their relative received. We saw that volunteer's spent time talking to people and supporting people with their lunch time meal.

People told us the staff supported them to maintain their independence, by encouraging them to do what they could for themselves. One person said, "I try to do things and ask when I need help." One person's visitor said the staff had 'encouraged' their relative and 'got them back on their feet' and that the care had been 'tremendous.'

People told us they were able to choose the gender of staff that supported them with their personal care needs. People confirmed they could get up and go to bed at times that suited them. This demonstrated that people's preferences were taken into consideration and respected.

People and their relatives told us they were consulted in the development and reviews of their care plans. Information in people's care plans confirmed this. We saw a poster regarding independent advocates was on display in the lobby. Advocacy is about enabling people who have difficulty speaking out to speak up and make their own, informed, independent choices about decisions that affect their lives. Although no one was using the services of an advocate at the time of our visit, the registered manager ensured people had this information available to them.

We saw that information was available in the entrance to the home regarding the 10 dignity standards. This is an initiative led by the National Dignity Council to promote awareness on how to support people in maintaining their dignity. One standard was regarding alleviating people's loneliness and isolation. A visitor told us that staff 'encouraged' their relative to join in activities, even though they usually declined to do so. This demonstrated that staff actively encouraged people to participate in social events to reduce isolation.

Visitors we spoke with told us they could visit at any time and were always made to feel welcome by the staff team. One person told us, "The staff here always make us feel welcome whenever we visit."

Requires improvement

Is the service responsive?

Our findings

People had mixed views about the activities available to them. People told us that bingo, quizzes, some physical exercises and crafts were provided on a regular basis. One person described the home as having 'plenty of entertainment' but another said “There doesn’t seem to be many activities.” This person told us they found life in the home, 'boring'. The majority of activities were group based rather than person-centred, which meant they were not tailored to meet everyone’s individual’s interests. One person said, “They are not the sort of activities that I like. I don’t like bingo or art and craft.” Another person said that they found it hard to relate to other people living at the home and said, “They do not have the same life experiences as me”. Another person told us they had nothing in common with the other people and preferred to stay in their room.

Some people confirmed that they preferred to stay in their rooms and confirmed this was respected by staff. Relatives of people who were cared for in bed confirmed that staff spent time with them. One person said the staff "make a fuss" of their relative and said staff “read to them every morning and have a natter.”

We saw that people had information recorded regarding their likes and dislikes and their life history. This information included people’s past interests and hobbies. Some people who were more physically independent told us they were supported to maintain outside interests. One person told us they liked to spend a large amount of time in the garden, and regularly went out to the local town. They told us, “I am not tied down. I can please myself.”

The activities coordinator was not on duty and we did not observe any group activities taking place on the day of our visit. However we did observe volunteers sitting and chatting with people during the morning.

We saw care plans were updated to identify any changing needs and relevant professionals were contacted when needed. We saw that in general staff had followed professional guidance to reduce the risks identified but this was not always done.

Visitors we spoke to confirmed that they had been involved in the planning of their relatives’ care. Care plans were regularly reviewed which meant the registered manager and staff knew when people’s needs and abilities changed. People’s visitors told us they felt well informed about their relative’s lives and welfare.

People we spoke with did not have any complaints about the service and told us that if they had any complaints they would report them. One person said, “I’d speak to the staff if I had any complaint." We saw there was a copy of the complaints policy on display in the home. Records were kept of complaints received and showed these had been addressed.

Requires improvement

Is the service well-led?

Our findings

People and their visitors told us and we saw that the home was in need of some refurbishment. People's relatives said they knew that the registered manager could not resolve some of these issues, as it was up to the provider to authorise any home improvements. Several people and their relatives told us that there was no walk-in shower available on the first floor. One person said that they didn't like having a bath, as it was more awkward and less comfortable for them. They said that in order to have a shower they had to be taken downstairs.

We saw that some toilet seats were worn, one of the ceiling fans in the first floor lounge did not work. Several areas around the home were in need of redecoration. The registered manager advised us that they had reported their concerns to senior management team and confirmed that a senior manager had recently visited to look at the repairs needed. The registered manager said they had not been advised when these repairs would be completed and was not aware of any refurbishment plan to ensure the home was kept in good repair.

We identified facilities that did not meet the needs of people that used the service. For example a bath on the ground floor, which could be adjusted up and down was not being used. The registered manager told us that this bath was not suitable for people with mobility needs as the hoist could not be used, due to the position of the bath. This showed us that the facilities available and refurbishment needed was not being suitably monitored or managed by the provider.

People and their relatives confirmed that their views were sought by the provider. The registered manager confirmed that the last satisfaction survey undertaken was in February 2014. The registered manager advised us they only received feedback from the provider when comments in satisfaction surveys identified concerns. This meant that the registered manager did not have an overview from satisfaction surveys to enable them to feed this back to people, their representatives and the staff team.

The registered manager analysed accidents, incidents and falls to identify any patterns or trends. This enabled the manager to take action to minimise the risks of a re-occurrence. We saw that other audits were in place such as medicines audits but some of these were not dated. This meant there was no clear audit trail in place to identify actions needed and monitor improvements. We saw that a medicines audit had been commenced for September 2015 and this was dated. Audits were undertaken regarding equipment such as hoists and we saw that equipment was serviced according to manufacturer's instructions.

The registered manager told us that staff meetings were held when needed and this was confirmed by staff. However no minutes were taken of these meetings, which meant no record was held to inform staff that were unable to attend.

People and their visitors described the registered manager as having an 'open-door' policy and said she was approachable. People told us that they thought that the home was very well run by the registered manager.

Staff we spoke with understood their roles and responsibilities and felt supported by the registered manager's leadership. They told us the registered manager was approachable and helpful. One member of staff said; "If I had any questions or concerns I would speak to the manager or the nurses." Comments from staff showed us that they enjoyed their job and worked well as a team. One member of staff said, "I love it here and it's because of the care. It needs some refurbishment but that isn't something the manager can authorise." Another member of staff said, "I love it, it's like a family."

There were appropriate data management systems in place. We saw that care records were kept securely, so that only staff could access them. Staff records were kept in a locked cabinet which meant they were kept confidentially and were available to the management team when needed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were not protected because some areas of risk had not been assessed. Where assessments were in place they were not always followed to ensure people were supported in a safe way.